7327 SW Barnes Rd. #219
Portland, Oregon 97225

www.SmileOregon.org
info@smileoregon.org

Health Care Provider's Information:

1. Health care provider name:
   First:____________________ Last:____________________
2. Degree(s):____________________
3. Health care provider's credentials:
   ____
4. Phone number: ____________________example (XXX)-XXX-XXXX
5. Email address:____________________
6. Address:
   Street address, P.O. Box, c/o: ____________________
   Apartment, suite, unit, building, floor, etc.: ____________________
   City, State, Zip Code: ____________________

Patient's Information:

7. Patient's Name
   First:____________________ Last:____________________
8. Patient's Birth Date:____________
   (MM/DD/YYYY)
9. Diagnosis(es)/Condition(s):

10. Relevant Medical History Statement:

11. Proposed Treatment Plan:

To coordinate comprehensive care and support for
the children and families of Oregon who are affected
by Cleft Lip and Palate and other Craniofacial conditions

smile OREGON

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12. How does the proposed treatment plan integrate with the patient's overall team care?

13. Proposed Start Date:

14. Estimated Length of Treatment:

15. Estimated Cost of Treatment: $______________

16. Do you anticipate the patient's health benefit plan covering any of the costs of the proposed treatment plan? (Please explain)

17. Other comments:

Health Care Provider's Statement:

As a provider I am properly credentialed to provide the proposed treatment plan. I am in good standing with my licensing board(s) and I am willing to work with Smile Oregon to facilitate delivery of the proposed treatment plan. As a provider I am willing to work closely with Smile Oregon's medical advisory committee. I understand that I may be requested to submit periodic progress reports, final records and follow-up records.
As a provider I am agreeing to the above statements, related to Smile Oregon policies, and I am stating that the information contained within the application is, to the best of my knowledge, true and accurate.

18. Signature____ Date:________________________